Temp. Permit No.

FORM B
RESPIRATORY CARE REFERENCE FORM

In order for the Georgia Composite Medical Board to adequately evaluate the applicant named below for certification to practice as a Respiratory Care Practitioner in the State of Georgia, please complete all pertinent sections in detail. This reference form must be completed and signed by a licensed physician with whom the applicant practices with at the time of application in another state as a Respiratory Therapist or previously practiced, or the Medical Director (licensed physician) who is in charge of the Respiratory Program of the school you are currently or recently a graduate. If the current Medical Director cannot complete the Reference Form, a Prospective Employer's Reference Form (Form B11) may be submitted instead. **An original signature is required for the Medical Director/Licensed physician.**

This form must be mailed **directly from the physician to** the Georgia Composite Medical Board **at the following address:**

Georgia Composite Medical Board
Respiratory Care Professional Unit
2 Peachtree Street, N.W. – 36th Floor
Atlanta, GA 30303

Section 1: - To Be Completed by Applicant:

Name: Last:_____________First:_______________________ M.I.:_______Maiden: ____________

Mailing Address: ____

____

Telephone Number: ____

Place of Employment or College Clinical if you are a student:_______________________________
____

City & State of location indicated above: ____

Section 2: To be completed by your current or previous Medical Director or the Medical Director of the Respiratory care Program of the school you are currently or recently attended.

Please evaluate the applicant in the following areas:

	Excellent	Good	Average	Poor	Not able to make judgment
Dependability	☐	☐	☐	☐	☐
Quality of Work	☐	☐	☐	☐	☐
Professional Responsibility	☐	☐	☐	☐	☐

Reference Form Continued On Next Page

FORM B - RESPIRATORY CARE REFERENCE FORM (continued)

(If the applicant is a student, you can omit this section)

Date Employment Started: month/________ day/____________ year/________

In your professional opinion is the applicant capable of performing competently as a Respiratory Care Professional? ☐ Yes ☐ No

Would you recommend certification based on applicant's abilities? ☐ Yes ☐ No
If no, please explain.

____

____

(If the applicant is a student, you can omit this section)

I hereby certify that the above applicant is or has been employed under my supervision as a health professional in Respiratory Care ***from*** **(mm/yy)**____/________ ***to*** **(mm/yy)** ____/_____

Applicant worked ☐ full time ☐ part time, approximately ___ hours per week.

Would you rehire? ☐ Yes ☐ No If no, please explain.

____

____

Additional Comments:

____

____

If you are completing this reference form, please list the name of the business, hospital, or school where you are currently practicing.

Name of Business, Hospital or School: ________________________________

City & State of above location: ____________________________________

Physician's Name: ***(please type or print)*** ____________________________

Physician's Signature: ____
(Original signature required)

License Number: ________________________ **State of Licensure:** ____________________

Business Telephone Number: ____________________ **Date:** ___________________________